

PRINTED: 03/07/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8206	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/24/2016
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE HOUSE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 BELLEBROOK RD BRISTOL, TN 37620			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During an annual Licensure survey and investigation of complaints #37585, #37744, #38046, and #38313 conducted on 2/22/16 through 2/24/16, at The Cambridge House, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE FORM

0890

493111

TITLE

(X6) DATE

If continuation sheet 1 of 1